HARRISON MEDICAL CENTER	**Financial Assistance Policy for the Uninsured & Underinsured**	*Page 1 of 9*	AC 1162
	Organizational	Creation: 01/15/09 Update/*Review: 09/27/12	RC 3 Yrs
	Owner(s): Dir. Patient Financial Services		
	Policy Category: 06. Charity Care	*Add a R to review dates	
Required Signature(s): VP/CFO			

Purpose:

This policy is intended to:

1. Define a clear and documented charity policy consistent with the hospital's mission and values
2. State the criteria used by the hospital to determine whether a patient is eligible for charity care
3. Establish the process that patients shall follow in applying for participation under the hospital's charity policy and the process the hospital will follow in reviewing, granting and denying applications for charity care
4. Provide an appeal process where a patient may seek an additional level of managerial review in the event of a dispute over a charity care determination
5. Establish the notice requirements regarding the hospital's charity policy

Background:

The mission of Harrison Medical Center is *"to make a positive difference in people's lives through exceptional medical care."* In order to ensure the future of this mission within our community we must remain financially healthy by receiving appropriate payment for the services we provide. In addition, our Financial Assistance practices comply with Washington State laws and Regulations. See Appendix A for Financial Assistance Guidelines.

Goal:

It is the goal that each patient who indicates financial difficulty in paying for healthcare services is fully and fairly evaluated and offered appropriate financial assistance.

Harrison is committed to not deny necessary medical care based on the inability to pay.

1. Harrison will provide a written notice to all patients informing them about the availability of financial assistance. In addition, signage is displayed in appropriate areas.
2. Harrison will actively support patients in their efforts to obtain appropriate financial assistance.
3. Uncompensated healthcare will not be denied based upon race, creed, color, sex, national origin, sexual orientation, disability, age or source of income.
4. Under all circumstances the collection practices of Harrison entities will be performed professionally and consistent with our mission and the Federal Fair Debt Collection Practices Act.

5. Harrison will comply with or exceed the State Of Washington legislative directives enacted by RCW 70.170.060[1] and WAC 246-453 and any updates.
6. Harrison will abide by and comply with the rules and monitoring of the Department of Health.
7. The Finance Committee of the Board will receive an annual report summarizing our collection activity.

Definitions and Eligibility:

1.1. "Allowance for financially qualified patient" means, with respect to covered services, as defined in Section 1.4, rendered to a financially qualified patient, as defined in Section 1.6, an allowance that is applied after the hospital's charges are imposed on the patient, due to the patient's determined financial inability to pay charges.

1.2. "Catastrophic Charity Care" refers to the hospital's charity care policy for a patient with high medical costs, as defined in Section 1.8.

1.3. "Charity Care" refers to full and partial charity care, special circumstance charity care, and catastrophic charity care. Approved Charity Care is valid for six months from the date of the approval.

1.4. "Covered Services" refers to all services that are required to be provided for treatment.

1.5. "Federal poverty level" means the poverty guidelines, updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of subsection (2) of Section 9902 of Title 42 of the United States Code[2].

1.6. "Financially qualified patient" means a patient who is all of the following:
   (a) A patient who is a self-pay patient, as defined in Section 1.11 or a patient with high medical costs, as defined in Section 1.8 or a special circumstance patient, as defined in Section 1.12.
   (b) A patient who has a family income that does not exceed 400 percent of the federal poverty level
   (c) A patient who does not have an INS status of non-immigrant visitor

1.7. "Full Charity Care" is a 100 percent write-off of the hospital's undiscounted charges for hospital services. Full charity care is available to patients:
   (a) Whose family incomes are at or below 200 percent of the most recent federal poverty level guidelines, see Appendix A; and
   (b) Who is a self-pay patient, as defined in Section 1.11.

1.8. "A patient with High Medical Cost" means a person whose family income does not exceed 400 percent of the federal poverty level, as defined in Section 1.5, if that individual does not receive a discounted rate from the hospital as a result of his or her third party coverage. For these purposes, "high medical costs" means any of the following:
   (a) Annual out-of-pocket costs incurred by the individual at the hospital that exceed 10 percent of the patient's family, as defined in Section 1.10, income in the prior twelve months.

(b) Documented annual out-of-pocket total medical expenses that exceed ten percent of the patient's family income, paid by the patient or the patient's family, as defined in Section 1.10, in the prior twelve months.

or

(c) Annual out-of-pocket costs incurred by the individual at the hospital that exceed 30 percent of the patient's family, as defined in Section 1.10, income (regardless of the percent of FPL) in the prior twelve months.

1.9. "Partial Charity Care" is a partial write-off of the hospital's undiscounted charges for hospital services. Partial charity care is available to patients:

(a) Whose Family Incomes are between 201% and 400% of the federal poverty level according to the most recent federal poverty income guidelines, see Appendix A; and

(b) Who is a self-pay patient, as defined in Section 1.11.

1.10. "Patient's family" means the following:

(a) For persons 18 years of age and older: spouse, domestic partner, and dependent(s)

(b) For persons under 18 years of age: parent, caretaker relatives and other dependent(s)

1.11. "Self-pay patient" means a patient who either does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, or has a self pay responsibility after payment by third-party coverage. A self-pay patient does not include one whose injury is a compensable injury for purposes of workers' compensation, third party liability or automobile insurance. Self-pay patients may include charity care patients. Where appropriate, the term "self-pay patient" may also refer to the patient's representative or the patient's guarantor.

1.12. Special Circumstances Charity Care refers to self-pay patients who do not meet the charity care criteria set forth in section 1.2 and or 1.3, above, or who are unable to follow specified hospital procedures, to receive a complete or partial write-off of the hospital's undiscounted charges for services, and who receive the approval of the Patient Financial Services Director, or designee. The hospital must document the decision, including the reasons why the patient did not meet the regular criteria. The following is a non-exhaustive list of some situations that may qualify for special circumstances charity care:

(a) Bankruptcy: self-pay patients who are in bankruptcy;

(b) Homeless Patients: self-pay emergency room patients, if the patient does not have a mailing address and/or residence.

(c) Deceased: self-pay deceased patients without an estate.

(d) Medicare: income-eligible (as determined by Section 3.2) Medicare patients may apply for special circumstance charity care for denied stays, denied days of care, non-covered services and Medicare cost shares;

(e) Medicaid: income-eligible (As determined by Section 3.2)Medicaid patients are eligible for special circumstance charity care for denied stays, denied days of care, and non-covered services; however, patients may not receive charity care

for the Medicaid share of cost. Persons eligible for programs such as Medicaid but whose eligibility status is not established for the period during which the medical services were rendered are eligible for charity care.

Procedure Criteria:

2. Applying for full or partial charity care:

2.1. A self-pay patient who indicates the financial inability to pay a bill for covered service will be evaluated to determine if they qualify for full or partial charity care.

2.2. The "Financial Assistance Program Application" ("Application"), see Appendix B, will be used to determine and document the patient's eligibility for charity care. The Application shall request documentation supporting the patient's or the patient's family monetary assets. In the event that the responsible party is not able to provide any of the documentation requested, the hospital shall rely upon written and signed statements from the responsible party for making a final determination of eligibility for classification as charity. Monetary assets shall not include statements on retirement or deferred compensation plans qualified under the Internal Revenue Code, or non-qualified deferred compensation plans. The hospital may obtain waivers or releases from the patient or patient's family, authorizing the hospital to obtain account information from financial or commercial institutions, or other entities that hold or maintain the monetary assets to verify their value.

2.3. If a self-pay patient does not complete the Application within 30 days of delivery, the hospital will notify the patient that the Application has not been received and will provide the patient an additional 30 days to complete the Application. Failure to complete and return the Application within the additional 30 days may result in the self-pay patient being denied charity care.

3. Charity Care Application Processing, Determination and Appeal

3.1. Determination:

(a) Upon the request of a self-pay patient, the hospital will provide the patient with a written notice that will contain information about the availability of the hospital's charity care policies, including information about eligibility, as well as contact information for a hospital employee or office from which the patient may obtain further information about these policies. The hospital will consider each applicant's Application and grant full or partial charity care where the patient meets eligibility requirements and has received (or will receive) covered service(s).

(b) Charity approval is contingent upon a patient applying for governmental program assistance, when appropriate.

(c) The hospital will assist the individual in determining if they are eligible for any federal, state, or other assistance.

(d) The hospital may offer an extended payment plan to self-pay patients qualifying for partial charity. The extended payment plan shall be interest free.

(e) If a charity determination is made and partial payment is required, payment is due in advance of service unless other arrangements, such as an extended payment plan, have been pre-arranged with the hospital.

3.2. Criteria: The Charity Care Discount Table ("Table"), Appendix A, shall be used as a guide by hospital staff in making charity determinations. The Table may not be used as the only criteria. The hospital staff shall apply sound judgment and materiality to each case when determining eligibility. The Table will be updated based on changes to the HHS Federal Poverty guidelines published in the Federal Register.

(a) An account may be deemed eligible for charity or partial charity before, during, or after of the provision of health care services. The patient's and/or guarantor's financial situation at the time of service shall be used to determine charity or partial charity eligibility.

(b) The following criteria may be used by hospital staff in evaluating charity and partial charity determinations:

1. Federal Poverty Guidelines
2. Eligible Monetary Assets as defined in Section 2.2
3. Employment Status and earning capacity
4. Family Size
5. Financial Obligations
6. Medical Bills

3.3 Timeline

(a) The initial determination of sponsorship status will be completed before or at the time of admission or soon as possible following the initiation of services.

(b) The responsible party will be provided with at least fourteen days or such time as the patient's medical condition may require, or such time as is reasonably necessary to secure and present documentation prior to the receiving a final determination of sponsorship status.

Failure of a responsible party to reasonably complete the appropriate application procedures within the guidelines (2.2.3) is sufficient grounds for Harrison to initiate collection efforts directed at the patient.

(c) Harrison must notify patients of the final determination within 14 calendar days of receiving all the information. This notification will include a determination of the amount for which the responsible party will be held financially accountable.

(d) If sponsorship is denied, Harrison notifies the responsible party of the denial and the reason for the denial. Harrison also provides the responsible party notification of the appeals procedure that will allow the party to correct any deficiencies or request a review of the denial and results.

(e) At any time during this process Harrison may pursue payment from third party payors.

3.4 Appeal Process:

(a) In the event of a request for an appeal and review, a patient may seek review from the hospital by notifying the Patient Financial Services Director, or designee, of the basis of any dispute and the desired relief.
(b) Written communication must be submitted, within thirty (30) days of the patient's receipt of their denial notice, with the circumstances giving rise to the dispute.
(c) The CFO or equivalent shall review the concerns and make a determination. Within Harrison Medical Center, the CFO equivalent may be determined to be the Director of Patient Financial Service.
(d) An appropriate designee will inform the patient of any decision in writing as to the denial and the basis for the denial.
(e) If the appeal decision is to affirm the initial denial then an appropriate designee will inform the department of health of the denial in writing of the decision, the basis for the decision and copies of the documentation upon which the decision was made.

3.5 Collection Efforts

(a) Collection efforts are administered according to state regulations as defined in each phase of the charity care determination timeline.
(b) Collection efforts include any demand for payment.
(c) No collection efforts can be initiated pending an initial determination, provided the responsible party is cooperative with Harrison's efforts to reach an initial determination.
(d) If the initial determination is such that patient might be eligible for sponsorship collection efforts are precluded until a final determination, provided the responsible party is cooperative with Harrison's efforts to reach a final determination.
(e) If a determination for sponsorship is denied and the responsible party has been informed of the denial decision and the process for appeal, the patient may not be sent to an external collection agency during the first 14 days following the notice of the denial decision.
After 14 days, Harrison may initiate collection activities.
If Harrison determines that an appeal has been filed then all collection efforts will cease until the appeal is finalized.

3.6 Refunds

(a) If a patient has made full or partial payment of all charges related to hospital care and is subsequently found to be eligible for charity care sponsorship, any payment in excess of the amount determined to be determined appropriate is refunded to the patient within 30 days of the charity care designation

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References Cited
1) http://apps.leg.wa.gov/rcw/default.aspx?cite=70.170.060
2) http://us-code.vlex.com/vid/sec-definitions-19245985

3) http://aspe.hhs.gov/poverty/12poverty.shtml/

Appendix A – Charity Care Discount Table

Family Size	Federal Poverty Level[3]			
	100%	200%	300%	400%
1	$11,170	$22,340	$33,510	$44,680
2	$15,130	$30,260	$45,390	$60,520
3	$19,090	$38,180	$57,270	$76,360
4	$23,050	$46,100	$69,150	$92,200
5	$27,010	$54,020	$81,030	$108,040
6	$30,970	$61,940	$92,910	$123,880
7	$34,930	$69,860	$104,790	$139,720
8	$38,890	$77,780	$116,670	$155,560
Each additional person	$3,960	$7,920	$11,880	$15,840
Charity Care Discount	**100%**	**100%**	**75%**	**50%**

Note: Federal Poverty Guidelines taken from '2012 Poverty Guidelines for the 48 Contiguous States and the District of Columbia' - http://aspe.hhs.gov/poverty/12poverty.shtml

Appendix B – Financial Assistance Program Application

It's our policy to make sure you are not refused the hospital-based care you need. Our financial assistance program offers care for free or at a reduced rate for those who qualify.

For those who qualify, our program offers:

- Financial aid for Harrison services not covered by insurance;
- Assistance from trained financial counselors to help complete Medicaid applications;
- Reduction of 38%, 52% or 100% depending on income eligibility.

Medicaid may pay for your medical expenses if you are younger than 19, or if you are pregnant, disabled or have a long-term illness.

A COMMUNITY RESOURCE

Peninsula Community Health Services (PCHS) offers low-cost medical and dental services through their clinics in Bremerton, Port Orchard, and Poulsbo. Fees are on a sliding scale based on income. PCHS also accepts DSHS medical coupons as well as Healthy Options, Basic Health, Medicare, TriCare and other private insurance reimbursements. For information, call 360-478-2366, or visit pchsweb.org.

For more information, call Patient Accounts at 360-744-3911, ext. 6175 or 360-744-6175.

FINANCIAL ASSISTANCE AT HARRISON

It is Harrison Medical Center's policy that no one be denied hospital-based health-care services, including emergency services, because of the inability to pay.

Harrison will provide hospital services free or at a reduced rate without discrimination to those with no or inadequate means to pay for needed care.

If you think you may be eligible for financial assistance, you may request an application from Patient Accounts, Registration, Cashier or Emergency departments. Verification of your income will be requested at the time you apply. Within 14 calendar days of your request, we will make final determination as to the amount of aid you may receive.

HARRISON'S FINANCIAL ASSISTANCE PROGRAM: INCOME ELIGIBILITY & RATE REDUCTION

Family Size	Combined Family Income (must be at or below the following levels)		
1	$11,170	$22,340	$ 33,510
2	$15,130	$30,260	$ 45,390
3	$19,090	$38,180	$ 57,270
4	$23,050	$46,100	$ 69,150
5	$27,010	$54,020	$ 81,030
6	$30,970	$61,940	$ 92,910
7	$34,930	$69,860	$104,790
8	$38,890	$77,780	$116,670
For each additional person, add: $ 3,960			
Updated Jan 2012	Bill 100%	Discount 52%	Level 38%

HARRISON
MEDICAL CENTER

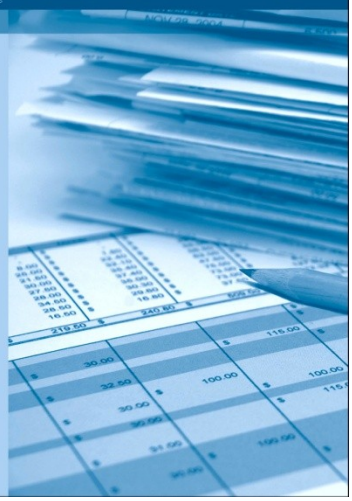
HELP WITH YOUR HOSPITAL BILLS

Are you eligible for financial assistance?

HARRISON MEDICAL CENTER
2520 Cherry Avenue
Bremerton, WA 98310
360-744-6174 phone
360-744-6188 fax

billing@harrisonmedical.org
harrisonmedical.org

HARRISON
MEDICAL CENTER



Financial Assistance Program
REQUEST FOR DETERMINATION OF ELIGIBILITY

HARRISON
MEDICAL CENTER

Patient Information:

Patient's name _____ Social Security number _____

Home phone _____ Cell phone _____

Patient's address _____ (NUMBER AND STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Current employer _____ Phone _____ Employed from _____ to _____

Previous employer _____ Phone _____ Employed from _____ to _____

Guarantor Information:

Responsible party _____ Social Security number _____

Home phone _____ Cell phone _____

Address _____ (NUMBER AND STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Current employer _____ Phone _____ Employed from _____ to _____

Previous employer _____ Phone _____ Employed from _____ to _____

PLEASE ATTACH INCOME VERIFICATION (REQUIRED TO PROCESS APPLICATION)

INCOME	Total for three months		Total for one year	
	Patient	Other family income	Patient	Other family income
Wages				
Self-employment income				
Public assistance				
Unemployment Comp				
Workers' Compensation				
Alimony				
Child support				
Pension or retirement				
Interest income				
Rental property income				
Other income (detail)				
Total income				

If there was no income, please explain in detail: _____

NUMBER OF DEPENDENTS IN HOUSEHOLD (INCLUDE SPOUSE)

Name	Relationship	Age	Name	Relationship	Age

The above information is true and correct to the best of my knowledge. I authorize Harrison Medical Center to verify any of the above information and grant permission for its release to Harrison Medical Center for the purpose of financial assistance eligibility determination.

DATE _____ SIGNATURE (PERSON MAKING REQUEST) _____

This information is confidential. Fax to 360-744-6188 or mail to Harrison Medical Center, Patient Accounts, 2520 Cherry Avenue, Bremerton, WA 98310